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H.R. 3716, Ensuring Terminated Providers are Removed from Medicaid and CHIP Act

FLOOR SITUATION

On Wednesday, March 2, 2016, the House will consider H.R. 3716, the Ensuring Terminated Providers are Removed from Medicaid and CHIP Act, under a structured rule. H.R. 3716 was introduced on October 8, 2015 by Rep. Larry Bucshon (R-IN), and was referred to the Committee on Energy and Commerce, which unanimously ordered the bill reported by voice vote as amended on November 18, 2015.

SUMMARY

H.R. 3716 would require States and Medicaid managed care plans to report to the Secretary of Human Health and Services (HHS) identifying information for providers terminated for reasons related to fraud, integrity and quality from Medicare or the Medicaid or Children's Health Insurance Program (CHIP). The bill would also require: providers participating in Medicaid or CHIP managed care to be enrolled with the State; CMS to include State reported provider terminations and Medicare provider terminations in its Termination Notification Database or equivalent system; and States to pay back the federal portion of Medicaid and CHIP payments made to terminated providers for services performed more than 60 days after a provider's termination is included in the CMS Termination Notification Database.[1]

H.R. 3716 also contains the text of H.R. 3821, introduced by Rep. Chris Collins (R-NY), which would require State Medicaid programs to provide beneficiaries served under fee-for-service (FFS) or primary care case management (PCCM) programs an electronic directory of physicians who have served Medicaid patients in the prior year. The Committee on Energy and Commerce also unanimously ordered the bill reported by voice vote as amended on November 18, 2015.

[1] See H. Rept. 114-427 at 4.

BACKGROUND

Prior to passage of the Patient Protection and Affordable Care Act (PPACA), a provider excluded from participation in one State's Medicaid program for fraud and abuse could potentially participate in another State's Medicaid program. To prevent this from happening, the PPACA required States to terminate the participation of a provider from its Medicaid program if the same provider's participation was terminated in another state for fraud or other criminal activity related to patient care.

However, the Department of Health and Human Services' Office of Inspector General (OIG) found continued participation of providers despite termination in another State. Specifically, the OIG found that 12 percent of providers terminated for cause from a State Medicaid program during 2011 (295 of the 2,539 providers) were participating in another State's Medicaid programs as of January 1, 2012.

The OIG report noted several challenges faced by States in implementing the PPACA requirement, including the lack of a comprehensive centralized data source that identifies providers terminated for cause; the lack of uniform terminology in existing data sources regarding the reasons for provider terminations; and challenges related to excluding providers participating in managed care since those providers may not be enrolled with the State Medicaid agency. H.R. 3716 would address the challenges and concerns raised by the OIG.[2]

Additionally, in its recent testimony before the Energy & Commerce Committee, the Government Accountability Office (GAO) identified access to care as one of the key issues facing the Medicaid program. While Medicaid beneficiaries enrolled in managed care plans have a defined network of providers, about half of states use delivery systems other than risk-based managed care, including FFS and PCCM programs to serve at least a portion of their Medicaid population. Many of these enrollees may have limited assistance in identifying physicians who participate in the Medicaid program. By requiring Medicaid programs that operate FFS and/or PCCM programs to include a directory of physicians who have participated in the Medicare program, H.R. 3716 would improve access to care by providing enrollees with the information they need.

COST

Originally, the Congressional Budget Office (CBO) estimated that enacting H.R. 3716 would reduce direct spending of Federal Medicaid outlays by $28 million over the 2016-2026 period. However, CBO estimates that enacting H.R. 3821 would increase direct spending by $13 million. Overall, H.R. 3716, as amended, saves $15 million.

Since the legislation would affect direct spending; pay-as-you-go procedures apply. Enacting the bill would not affect revenues. Additionally, CBO estimates that H.R. 3716 would not increase net direct spending or on-budget deficits in any of the four consecutive 10-year periods beginning in 2027. While CBO does not provide State-specific estimates, because Medicaid expenditures are Federal-State expenditures, State Medicaid programs would also save money under the policy from not paying providers who had been terminated in other states.

[2] Id.

AMENDMENTS

1. Rep. Larry Bucshon (R-IN)—The MANAGER'S AMENDMENT makes technical changes to the bill. The amendment changes the short title to better capture both sections of the bill and changes the effective dates throughout the bill to ensure that states and the Secretary of Health and Human Services have the time (10 minutes) necessary to correctly implement the provisions. The amendment adds a requirement for the Inspector General of the Department of Health and Human Services to report on implementation of the requirements regarding providers disenrolled for reasons related to fraud, integrity and quality. Finally, the amendments clarify that the fee-for-service provider directory is to include physicians and, at state option, other providers, and provides other information that could be included in the directory.

2. Rep. Sheila Jackson Lee (D-TX)—The amendment provides that determination of ineligibility to work for a Medicaid or CHIP provider does not take effect until the deadline for appeal that determination has expired.

3. Rep. Sheila Jackson Lee (D-TX)—The amendment seeks information on the demographics of the people who are provided healthcare by terminated Medicaid providers.

4. Rep. Gwen Moore (D-WI)—The amendment requires states to correct on an expedited basis directory information regarding whether the provider is accepting new Medicaid patients.

STAFF CONTACT

For questions or further information please contact Molly Newell with the House Republican Policy Committee by email or at 2-1374.